

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be left with the physician), and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18, then any injury, or other traumatic event, the medical examiner must be notified.

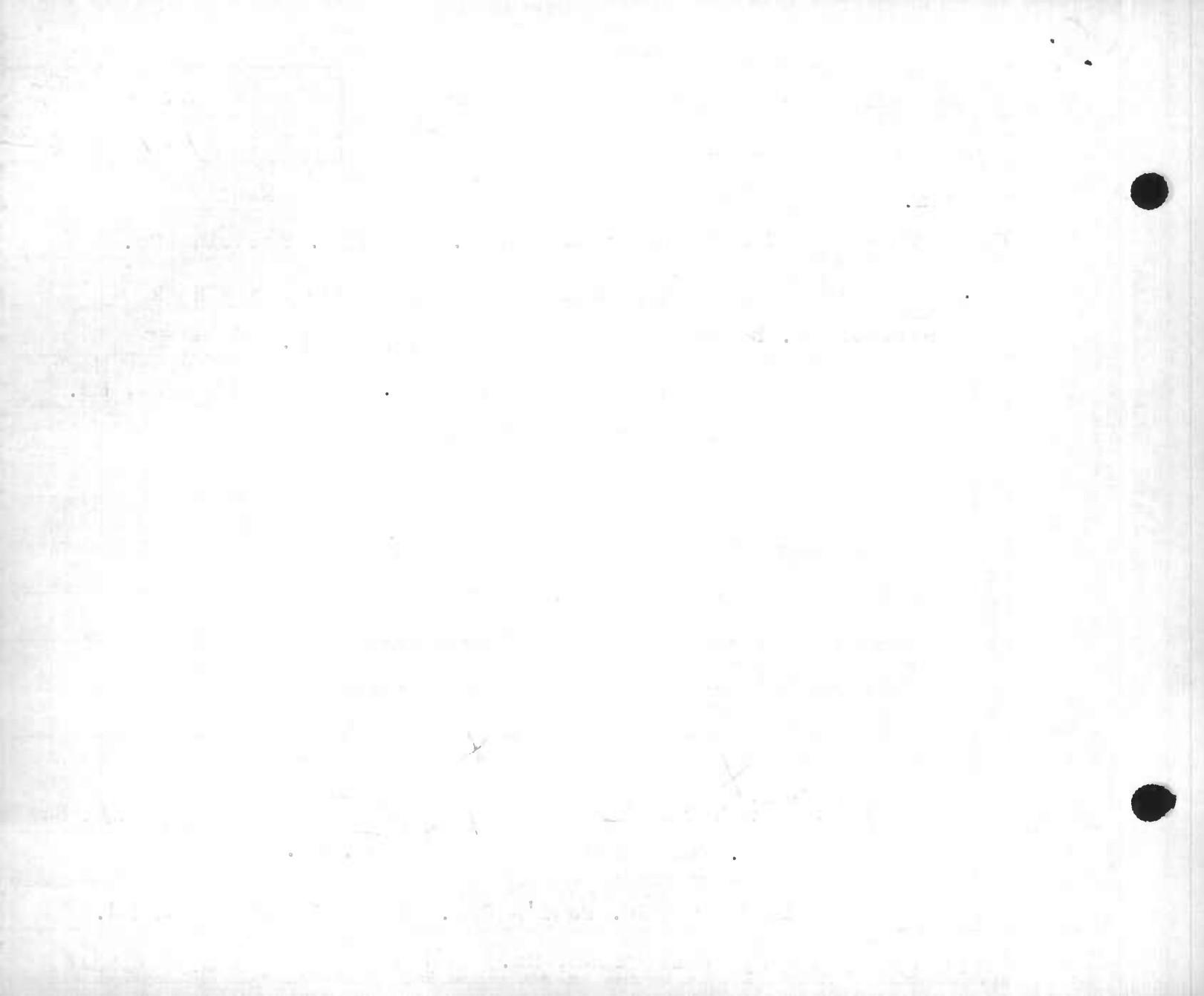
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 4 0 2 1 0 8					
										REG. NO.					
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
		Margaret			JONES		Anthony	January 21, 1984						2:36 p m	
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White			Nov. 28, 1916			67			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.				
Maryland		USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Kent			MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Chestertown		Kent & Queen Anne's Hospital			Bank Teller			Banking							
13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Millington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Cypress St. #151							
14. FATHER'S NAME Jonathan		MIDDLE	Jones	LAST	15. MOTHER'S MAIDEN NAME Daysie		MIDDLE	Felton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN)		16b. SOCIAL SECURITY NO. 213-05-7248			17. INFORMANT Charles H. Anthony		ADDRESS husband same								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1830										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED					
22b. SIGNATURE <i>Patrick Moloney</i>										DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick MOLONEY										ADDRESS Chestertown Medical Bldg 21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 1/24/84			23c. NAME OF CEMETERY OR CREMATORIAL Millington Cem.			23d. LOCATION CITY OR TOWN Millington, Kent, MD			COUNTY	STATE		
24. FUNERAL DIRECTOR Edw. Fellows & son Millington, MD 21651										25a. DATE REC'D. BY REGISTRAR JAN 30 1984					
										25b. REGISTRAR'S SIGNATURE <i>John J. Conroy</i>					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. AND 3 TO THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED			MONTH	DAY	YEAR	1st HOUR	
Berthold Christopher					BOTHE	<input type="checkbox"/> 1/1/84 <sub>19</sub>			6:59			6:59	
SEX	RACE	3. DATE OF BIRTH MONTH DAY YEAR	4. AGE (IN YEARS LAST BIRTHDAY) YRS.	5. IF UNDER 1 YR.	6. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.	2c. DATE PRONOUNCED DEAD			2d HOUR
male	white	5/17/1950	33							1-1	1984	6:50	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
Penn.		USA								Kent			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Chestertown		Kent & Queen Anne Hosp.						Mgr. Printing Co.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		21661			
Md.		Kent		Rock Hall				RFD Piney Neck					
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
Berthold W. Bothe					Sylvia M.				Atwater				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		ADDRESS		Piney Neck					
no		217 54 5003		Susan S. Bothe		Rock Hall, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) Probable ventricular fibrillation												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4274 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b) _____ DUE TO, OR AS A CONSEQUENCE OF  (c) _____ DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE RLW. Farr		TITLE SPECIFY M.D. Deputy MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS										DATE SIGNED	
Robert W. Farr Chestertown, Kent Co. Md.												1/2/84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 1/4/84		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cem. near Chestertown, Md.			23d. LOCATION CITY OR TOWN		COUNTY	STATE			
Burial													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 10 1984			25b. REGISTRAR'S SIGNATURE John J. Conigli						
J.W. Wells		Chestertown, Md.											
BP													
DHMH-17 (VR A15 ME(5)) 15M 2/80													



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 0 2 1 1 0			
												REG. NO.			
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Mary			CATHARINE Brown						1 24 84			5 10 PM			
3. SEX Female			4. RACE W			5. DATE OF BIRTH MONTH DAY YEAR 4 05 05			6. AGE (IN YEARS LAST BIRTHDAY) 88			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent			10. CITY OR TOWN OF DEATH Chesterstown			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Hall Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Insurance Broker			12b. KIND OF BUSINESS OR INDUSTRY Insurance			13a. STATE Md			13b. COUNTY Kent			
13c. CITY OR TOWN Chesterstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Maple Avenue 1620			14. FATHER'S NAME JAMES GALE BECK			15. MOTHER'S MAIDEN NAME MAMIE CATLIN BECK.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-32-1154			17. INFORMANT H. GILPIN BROWN			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4310 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { b). DUE TO, OR AS A CONSEQUENCE OF (c)			ADDRESS 8829 ELM ROAD RICHMOND VA 23235		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days 10 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) <input type="checkbox"/> attended the deceased from 1-1-84 to 1-24-84, shot (I) <input type="checkbox"/> lost saw the deceased alive on 1-24-84, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did <input type="checkbox"/> not view the body after death.												22b. SIGNATURE A.C. Dick			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.C. Dick			22e. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-24-84						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/27/84			23c. NAME OF CEMETERY OR CREMATORIAL CHESTER CEMETERY			23d. LOCATION CITY OR TOWN CHESTERTOWN COUNTY KENT STATE Md.						
24. FUNERAL DIRECTOR Marvin V. Willis Jr			ADDRESS CHESTERTOWN, Md.			25a. DATE REC'D. BY REGISTRAR FEB 03 1984			25b. REGISTRAR'S SIGNATURE John J. Conroy						

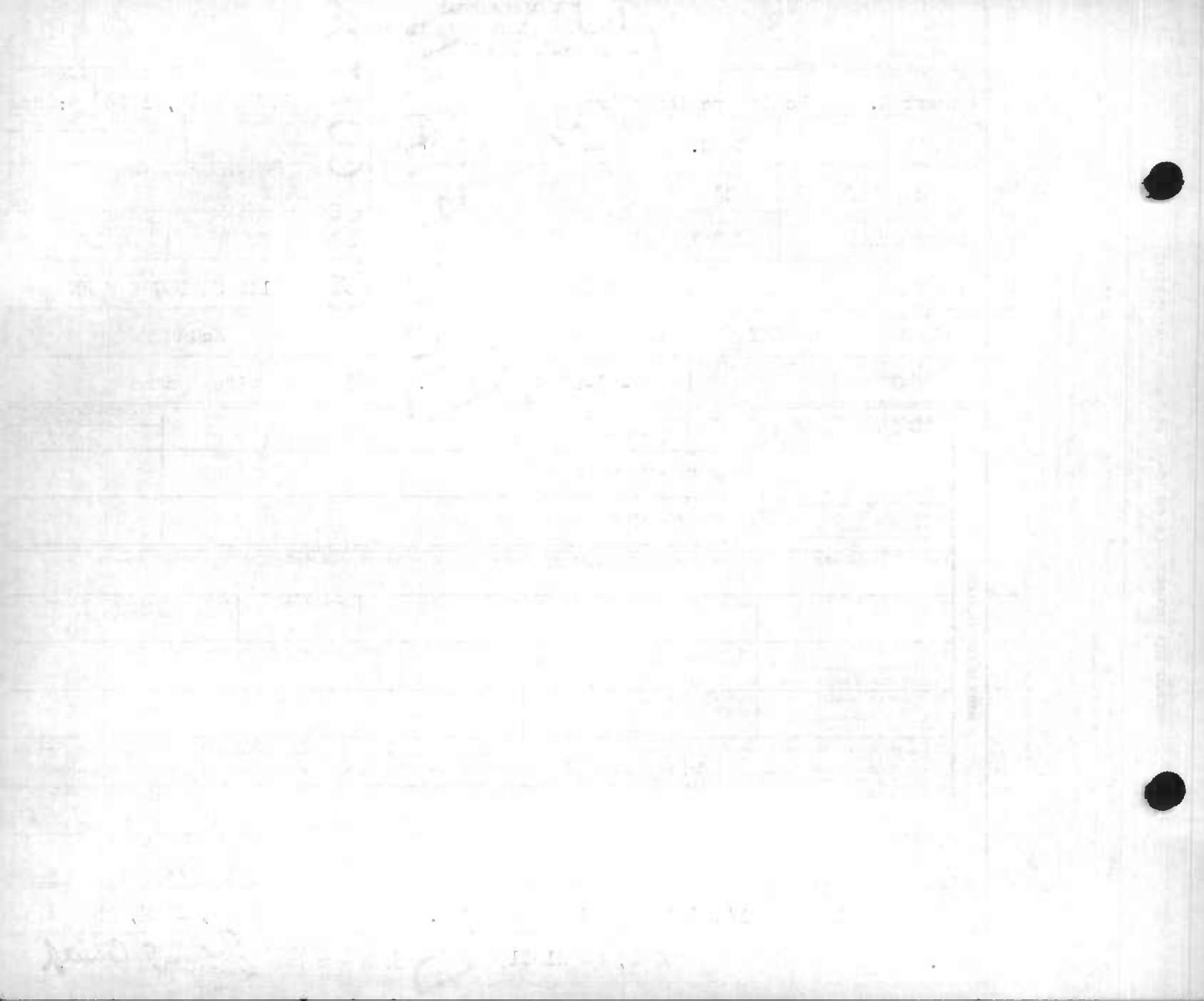
Missouri 18380 833

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or here [ ] shows any injury, or other traumatic event, the medical examiner must be informed at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 4 0 2 1								
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Robert A. AKA Robin Archibald Cunningham												JANUARY 15, 1984						6:00pm		
3 SEX			4 RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
/ MALE			CAUC.			MONTH JUNE			DAY 3			YEAR 1903			80		YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH					
COLORADO			USA												KENT					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY											
CHESTERTOWN			MAGNOLIA HALL NURSING HOME			STATISTICIAN			SELF											
13a STATE			13b COUNTY			13c CITY OR TOWN			13d. INSIDE CITY LIMITS?			14 STREET ADDRESS								
MARYLAND			KENT			KENNEDYVILLE			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			RD# BOX 123 KENTMORE PARK								
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																	
BURTON DARLEY CUNNINGHAM			MARGUERITE																	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS											
NO			222-01-0970			LAURA L. CUNNINGHAM wife			same											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lung												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months								
1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)																				
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
			P.M. 19																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (the hospital) attended the deceased from July 25, 1983, to January 15, 1984, that (I) (we) last saw the deceased alive on 12/3/1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.																				
22b. SIGNATURE <i>Charles P. Adams MD</i>															22c. DATE SIGNED Jan. 17, 1984					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN										
C. P. Adams M.D.			Chesterstown, Md.			<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY		STATE						
BURIAL			1/23/84			SHREWSBURY CEM.			KENNEDYVILLE, KENT, MD											
24 FUNERAL DIRECTOR NAME			EDW. FELLOWS & SON MILLINGTON, MD 21651			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
									JAN 19 1984			<i>John J. Carroll</i>								



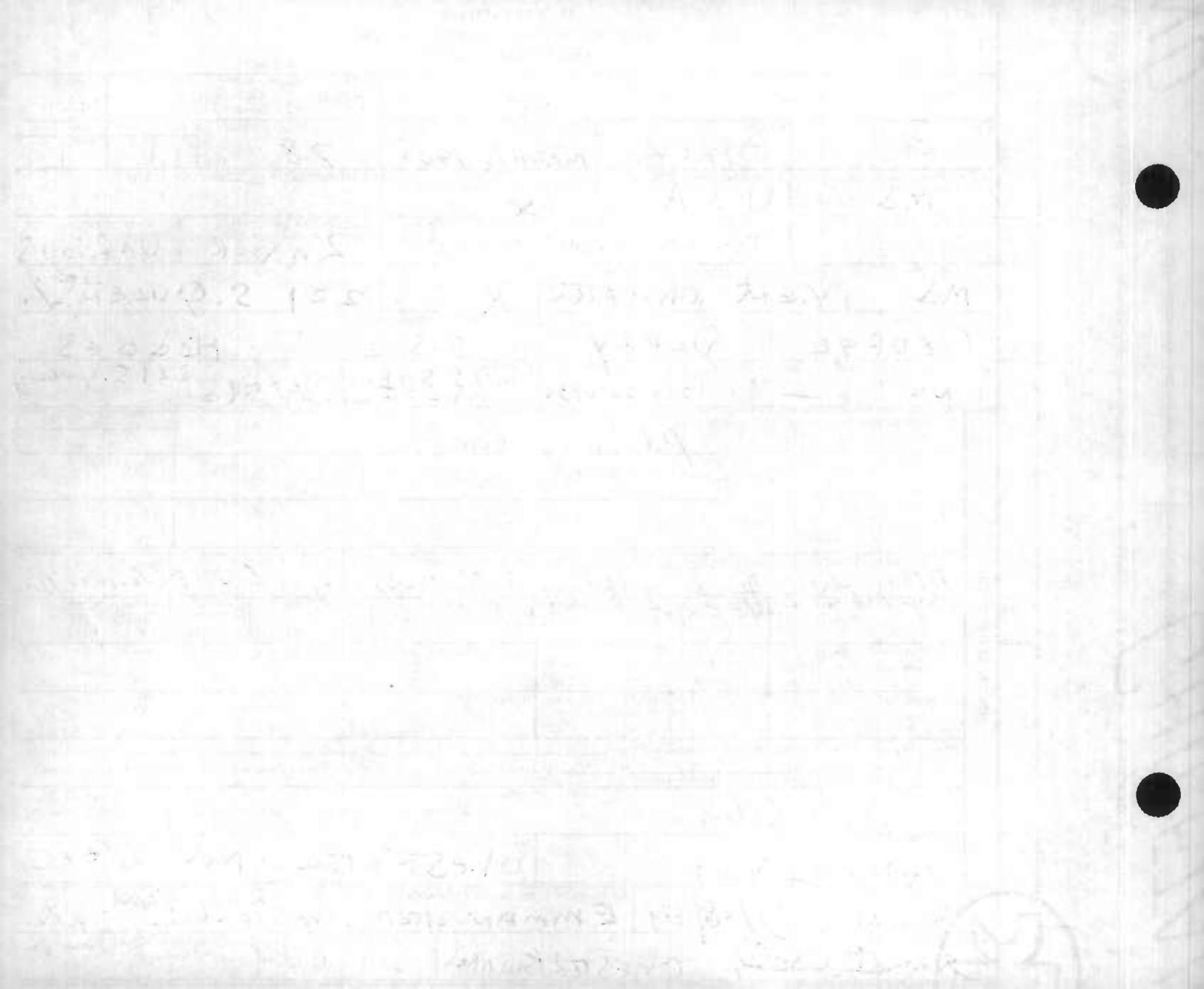
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IMPROVED

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										84 02112					
										REG. NO.					
1. FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)			FIRST Samuel	MIDDLE NMN	LAST Derry	2a. DATE OF DEATH			MONTH January	DAY 22	YEAR 1984	2b. HOUR 4:26p M	
3. SEX Male		4. RACE Black			5. DATE OF BIRTH MONTH MARCH DAY 15 YEAR 1905			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR 78	IF UNDER 24 HRS YRS.	MONTHS DAYS	HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent			MD.				
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor			12b. KIND OF BUSINESS OR INDUSTRY Various							
13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 221 S. QUEEN							
14. FATHER'S NAME GEORGE		15. MOTHER'S MAIDEN NAME SUSIE			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-20-0735		17. INFORMANT miss SARAH DERRY CHESTER TOWN, MD.			ADDRESS 221 S. QUEEN ST.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5860 Pulmonary arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
(b) _____ { DUE TO, OR AS A CONSEQUENCE OF															
(c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a (1) Obstructive Decalcification (2) R/O Malignancy in liver (3) Chronic Bronchitis															
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE J. L. Allen										DEGREE	22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KIN KUE WUN		22e. ADDRESS CHESTERTOWN, MD. 21620			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BUAI		23b. DATE 1/28/1984			23c. NAME OF CEMETERY OR CREMATORIAL EMMANUEL/CEN			23d. LOCATION CITY OR TOWN CHESTER TOWN		COUNTY Kent	STATE MD.				
24. FUNERAL DIRECTOR NAME Fernell Wally		ADDRESS CHESTER TOWN			25a. DATE REC'D. BY REGISTRAR JAN 26 1984			25b. REGISTRAR'S SIGNATURE John J. Connelly							
BP _____															
DHMH - 16 50M 4/82 (VRA 15, 4)															

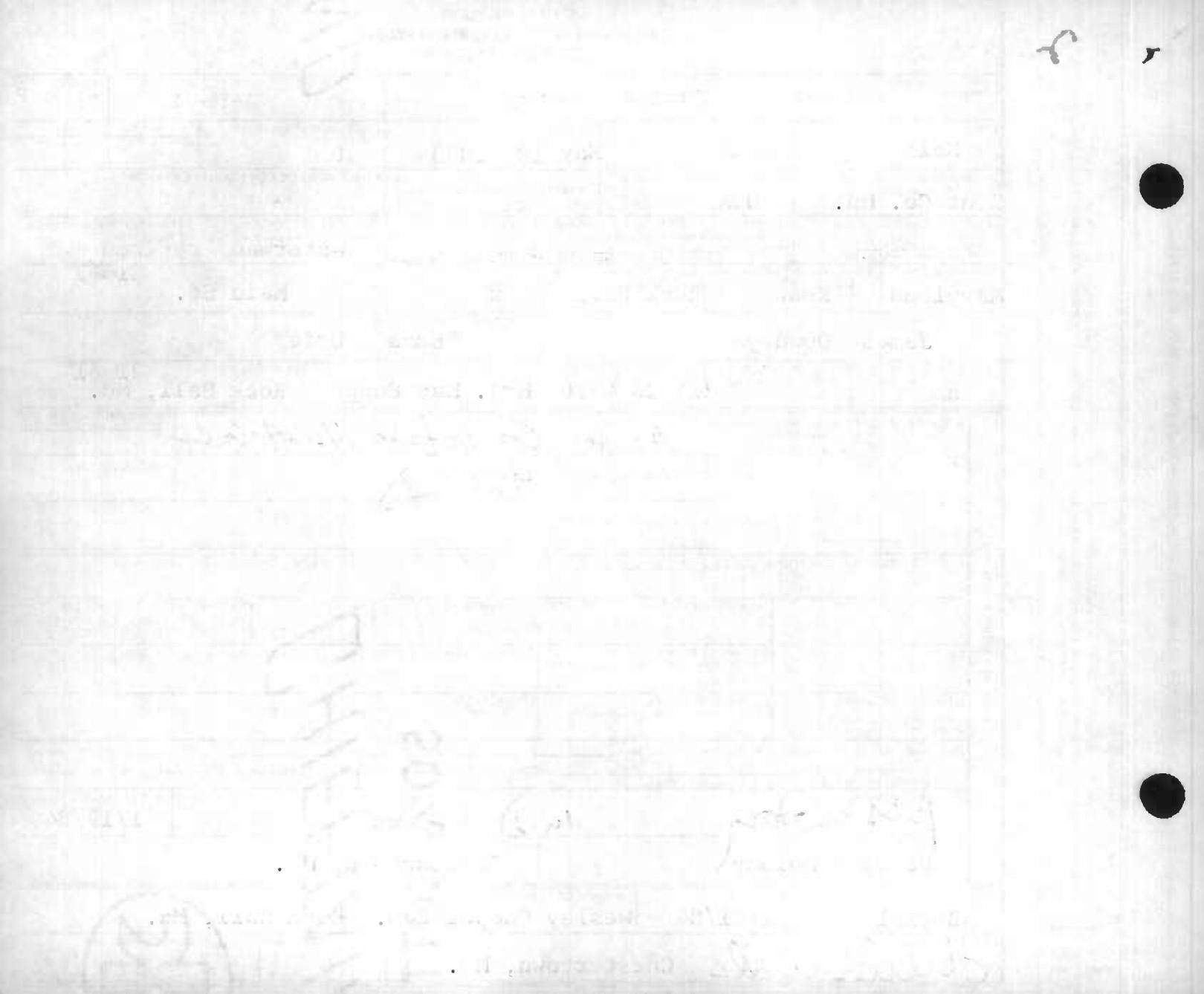


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "No", Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 0 2 1 3											
												REG. NO.											
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST James			MIDDLE Maurice			LAST Downey			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 7:50 p m					
3. SEX Male			4. RACE white			5. DATE OF BIRTH MONTH May			DAY 18			YEAR 1893			6. AGE (IN YEARS LAST BIRTHDAY) 90			IF UNDER 1 YEAR MONTHS YRS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent			10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Annes Hospital Inc.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman retired			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Kent			13c. CITY OR TOWN Rock Hall			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Main St.			21661								
14. FATHER'S NAME James Downey			15. MOTHER'S MAIDEN NAME Emma Uriel			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 26 4770			17. INFORMANT Mrs. Mae Puppe			ADDRESS 21661 Rock Hall, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) <i>Acute Congestive heart failure</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			DUE TO, OR AS A CONSEQUENCE OF (b) <i>HSCo D</i>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <i>Patrick Molony</i>			22c. DEGREE <i>C.A.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 1/19/84														
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick Molony			22f. ADDRESS Chestertown, Md.																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/21/84			23c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel Cem.			23d. LOCATION CITY OR TOWN Rock Hall, Md.			23e. COUNTY STATE											
24. FUNERAL DIRECTOR NAME <i>Willie Wells</i>			ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR JAN 27 1984			25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>														



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3 4 0 2
1. DECEASED NAME (TYPE OR PRINT)			FIRST Mae	MIDDLE	LAST Duxbury	2a. DATE KNOWN OF ESTI. DEATH MATED	MONTH 1	DAY 17	YEAR 1984	2b. HOUR P M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR 5/1/1921	6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD MONTH 1	DAY 17	YEAR 1984	2d. HOUR 5 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Phila. Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED XX		NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Kent			
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne Hosp.					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.	13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS xx RFD Tolchester		21620					
14. FATHER'S NAME FIRST John Paul Davis			15. MOTHER'S MAIDEN NAME FIRST Helen D. Johnson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 191 22 3792			17. INFORMANT ADDRESS RFD Tolchester Frank Duxbury Chestertown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4274 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. None												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Robert W. Farr		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED		1/18/84				
EXAMINER'S NAME (TYPE OR PRINT)			Kent Co.			ADDRESS			Chestertown, Md. 21620			
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial			23b. DATE 1/20/84			23c. NAME OF CEMETERY OR CREMATORIAL St. John's Catholic			23d. LOCATION CITY OR TOWN Rock Hall, Md.			
24. FUNERAL DIRECTOR NAME J. Willis Wells			ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR JAN 27 1984			25b. REGISTRAR'S SIGNATURE John J. Conroy			
BP _____												
DHMH - 17 (VR A15 ME (5)) 15M 2/80												

— میری روزگار کی میں اپنے بھائیوں کی دلچسپی کی وجہ سے

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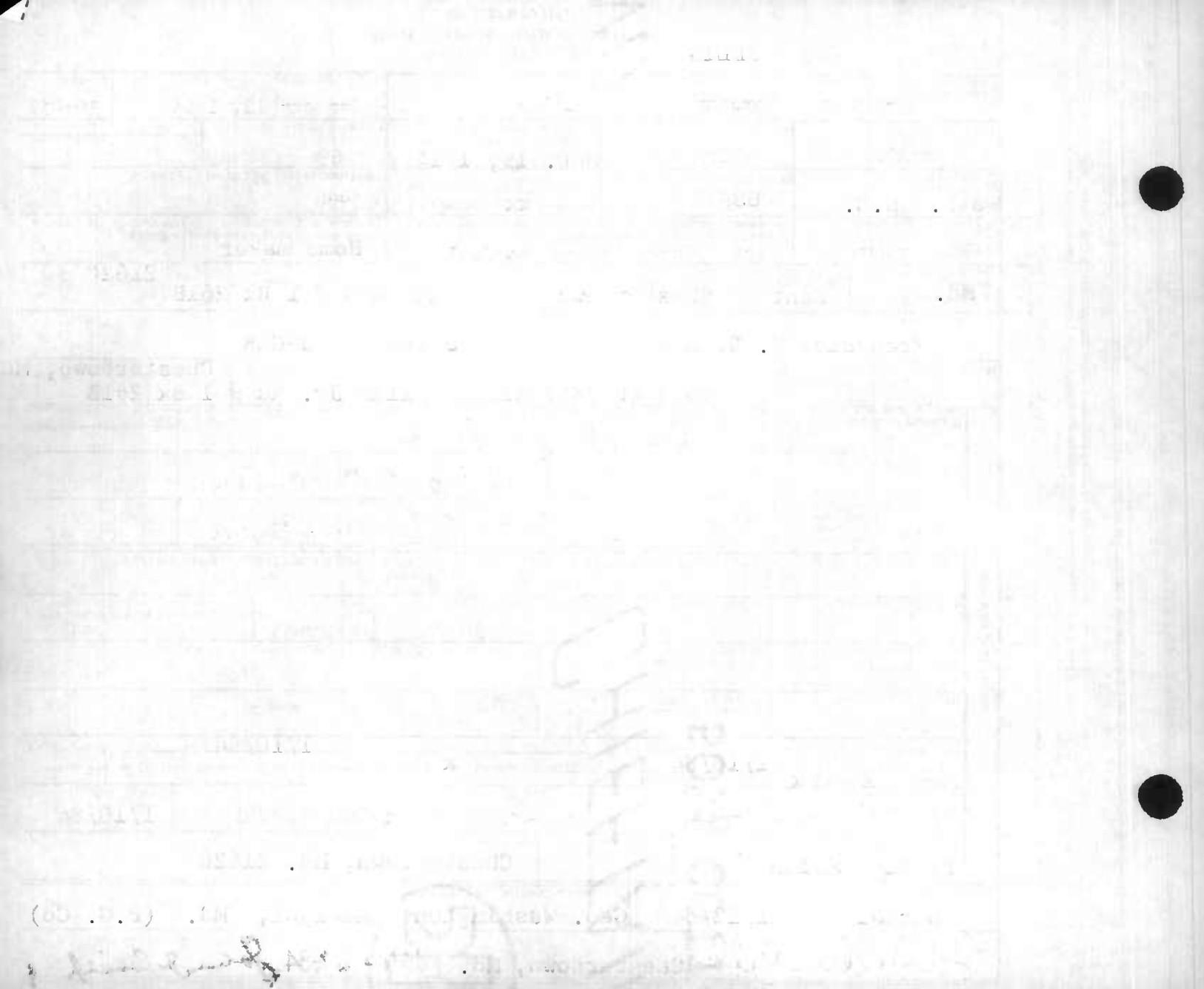
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 4 0 2 1 1 5			
1. FOR STATE REGISTRAR		ELLIS			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)	FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Rebecca	Dorothy					Ellis	January 10, 1984				10:05A		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		Oct. 19, 1914		69		MONTHS	YEARS	MONTHS	HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
Wash. D.C.		USA				Kent							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Chestertown		Kent & Queen Anne's Hospital		Home maker				21620					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
Md.		Kent		Chestertown				RFD # 1 Bx 261B					
14. FATHER'S NAME		FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME		LAST					
Frederick W. Becker						Jeanette UNGER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		Chestertown, Md.					
no		578 40 7867		Ellery Ellis Jr. Rd # 1 Bx 261B									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal Failure</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any (b) <i>Probable Septicemia</i> (c) <i>Bronchopneumonia</i>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1/10/84</i> , 19_____, to <i>1/10/84</i> , 19_____, that (I) (we) last saw the deceased alive on <i>1/10/84</i> , 19_____, and that in (my) ( <input checked="" type="checkbox"/> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <input checked="" type="checkbox"/> ) (did) ( <input checked="" type="checkbox"/> ) view the body after death.													
22b. SIGNATURE <i>Patrick Molony</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/10/84</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick Molony		22e. ADDRESS Chestertown, Md. 21620											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/12/84		23c. NAME OF CEMETERY OR CREMATORIAL Geo. Washington		23d. LOCATION CITY OR TOWN Adelphi, Md. (P.G. Co.)							
24. FUNERAL DIRECTOR NAME <i>Willie Wells</i>		ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR JAN 2 1984		REGISTRAR'S SIGNATURE <i>John C. Smith</i>							



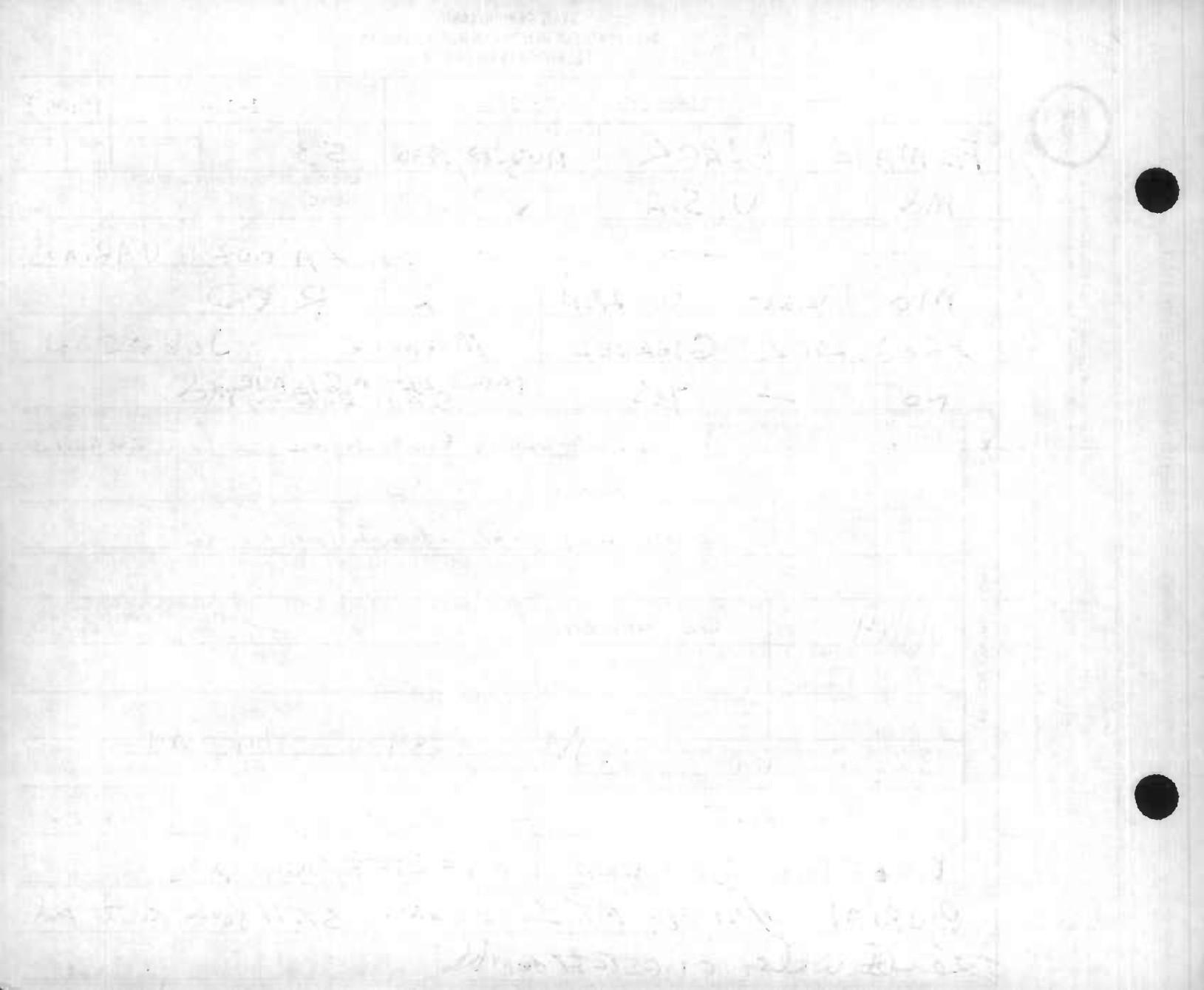
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							8 4 0 2	6	
							REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>Pearl</b>	MIDDLE <b>Elizabeth</b>	LAST <b>Griffin</b>	2a. DATE OF DEATH	MONTH <b>1-14-84</b>	DAY YEAR	2b. HOUR <b>10:09 P M</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>AUG. 18,</b> DAY <b>1930</b> YEAR		6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE COUNTRY <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Kent</b>		MD.	
10. CITY OR TOWN OF DEATH <b>Chestertown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Kent &amp; Queen Annes Hospital, Inc.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Labor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Various</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Kent</b>		13c. CITY OR TOWN <b>Worton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>R-50 21678</b>	
14. FATHER'S NAME FIRST <b>FREDERICK</b>		MIDDLE <b>G</b>	LAST <b>LEAVES</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Mamie</b>		MIDDLE <b>J</b>	LAST <b>Johnson</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>—</b>		17. INFORMANT <b>Mrs. Edna G. LEAVES</b>		ADDRESS <b>S. 11 8th St., S. Md.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 hours</b>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Phlebitis @ leg</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diversion of ureters - lymph node biopsy</b></p>									
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).</p>									
19a. DATE OF OPERATION <b>11/14/84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca shoulder</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
<p>22a. I certify that (I) (this hospital) attended the deceased from <b>8/18/84</b>, to <b>1/14/84</b>, to <b>1/14/84</b>, that (I) (we) last saw the deceased alive on <b>1/14/84</b>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>									
22b. SIGNATURE <b>E. GOTTFRIED BAUMANN</b>		DEGREE <b>key</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/17/84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. GOTTFRIED BAUMANN</b>		22e. ADDRESS <b>Chestertown, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/21/84</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>MT. Zion Cem.</b>		23d. LOCATION CITY OR TOWN <b>57-11 Park Kent Rd.</b>		STATE	
24. FUNERAL DIRECTOR NAME <b>Ben Weller</b>		ADDRESS <b>Chestertown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 23 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Jan 23 1984</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

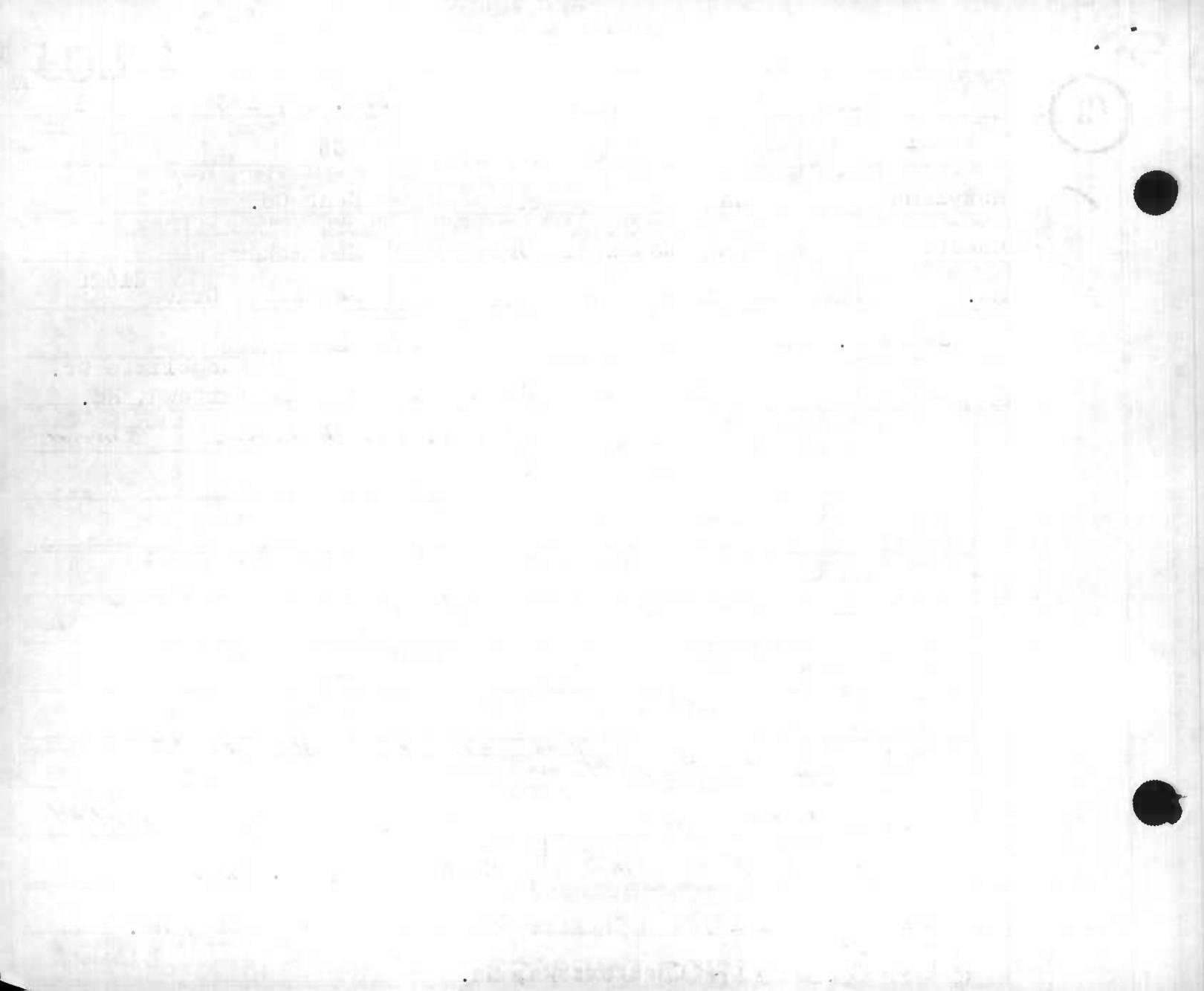
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "Yes", show any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 4 0 2 1 1 /		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
ROSE V HADAWAY						Jan. 15, 1984						A
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
female		white	Oct 29, 1895			88			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA						Kent Co.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Chestertown		At Home Radcliffe Drive			Homemaker							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		21620		
Md.		Kent		Chestertown				Radcliffe Drive				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST			
		James E. Walbert			Sarah Larrimore							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS		Radcliffe Dr.			
no		215 38 1489			Greta Walbert		Chestertown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronaria of Cecum w/ Metastasis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 month</u>												
1534 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>none</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>Sun 14 Jan 84</u> to <u>Sun 15 Jan 84</u> , that (I) (we) last saw the deceased alive on <u>Sun 14 Jan 84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Susan K. Ross MD</u>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>1/17/84</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Susan K. Ross MD.</u>		22e. ADDRESS <u>Chestertown, Md. 21620</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/17/84		23c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery			23d. LOCATION CITY OR TOWN Chestertown, Md.		COUNTY		STATE	
24. FUNERAL DIRECTOR <u>Willie Wells</u>		ADDRESS <u>Chestertown, Md.</u>			25a. DATE REC'D. BY REGISTRAR JAN 20 1984			25b. REGISTRAR'S SIGNATURE <u>John J. Conroy</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-trait permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "no" item 18 should only apply to other traumatic event, then medical certificate must be signed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 4 0 2 1 1 8					
										REG. NO.					
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST Josephine	MIDDLE Hugg	LAST Holden	2a. DATE OF DEATH			MONTH 1-4-84	DAY	YEAR	2b. HOUR 1:40AM	
3. SEX  Female		4. RACE  CAUC.			5. DATE OF BIRTH MONTH 12			DAY 22	YEAR 94	6. AGE (IN YEARS LAST BIRTHDAY) 89			IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. DAYS HOURS MIN.	
7. BIRTHPLACE COUNTRY MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent			MD.				
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Anne's Hospital Inc.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home							
13a. STATE MARYLAND		13b. COUNTY Q.A.		13c. CITY OR TOWN CHURCH HILL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS MAIN ST.			21623			
14. FATHER'S NAME FIRST HENRY		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Alice									Collier		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-20-6719-D			17. INFORMANT Betty Needles			ADDRESS 311 WASH. AVE CHESTERSTOWN MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5621 IMMEDIATE CAUSE (a) Sepsis and peritonitis secondary to perfora-										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) of large bowel (perforated diverticulum).															
{ DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____ to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Robert Farr		22c. DATE SIGNED 1/15/84			Degree MS	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert FARR MD		22e. ADDRESS HIGH ST. CHESTERSTOWN MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-6-84		23c. NAME OF CEMETERY OR CREMATORIAL Sudlersville Cem.			23d. LOCATION CITY OR TOWN Sudlersville			COUNTY QA	STATE MD				
24. FUNERAL DIRECTOR NAME EDW. Fellows + Son		ADDRESS MILLINGTON MD			25a. DATE REC'D. BY REGISTRAR 21651 JAN 18 1984			25b. REGISTRAR'S SIGNATURE John J. Conner							

Hall

X

24 West Dell

5

First book of ABNORMALS

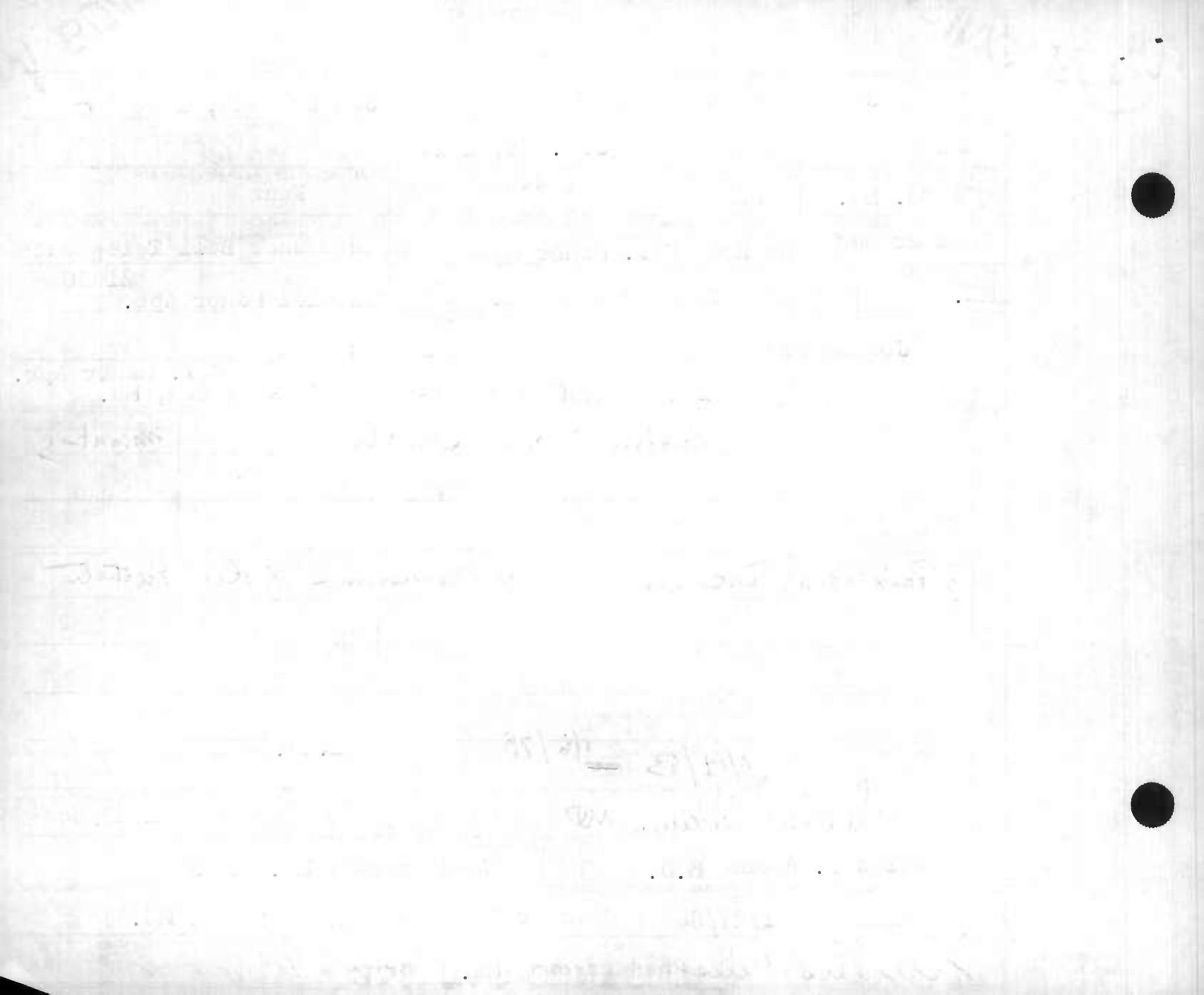
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 4 0 2		
										REG. NO.		
1 - STATE REGISTRAR	1 DECEASED NAME (TYPE OR PRINT)			FIRST JOHN	MIDDLE EVANS	LAST MASSEY	2a DATE OF DEATH	MONTH January	DAY 23	YEAR 1984	2b HOUR 6 P M	
	3 SEX male			RACE white	5 DATE OF BIRTH MONTH Jan.		DAY 28	YEAR 1914	6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		# UNDER 1 YEAR MONTHS 0	# UNDER 24 HRS DAYS 0
	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Q'A Co. Md.			7b. CITIZEN OF WHAT COUNTRY? USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Kent MD.			
	10 CITY OR TOWN OF DEATH Chestertown			11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home Col. Manor Apts			12a USUAL OCCUPATION Maintenance Bell Telephone			12b. KIND OF BUSINESS OR INDUSTRY		
	13a STATE Md.			13b. COUNTY Kent			13c. CITY OR TOWN Chestertown			13d. STREET ADDRESS Colonial Manor Apt. 21620		
	14 FATHER'S NAME FIRST Josiah Massey			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Helen			MIDDLE Gooding	LAST		
	16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b SOCIAL SECURITY NO WW 2 192 22 2830			17 INFORMANT Helen Massey			ADDRESS Col. Manor Apt. Chestertown, Md.		
	18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Sudden Cardiac Death</i> <i>4299</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i>	
	DUE TO, OR AS A CONSEQUENCE OF (b) _____											
	DUE TO, OR AS A CONSEQUENCE OF (c) _____											
	PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>✓ Parkinson's Disease</i> <i>✓ Cancer of the Prostate</i>											
	19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		
	21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
	21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
	22a I certify that (1) (this hospital) attended the deceased from <i>6/14/83</i> to <i>1/6/78</i> , 19_____, to <i>1/23/84</i> , 19_____, that (1) (we) lost saw the deceased alive on <i>6/14/83</i> 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (I) (did not) view the body after death.										22c. DATE SIGNED 1/23/84	
	22b. SIGNATURE <i>Charles P. Adamo MD</i>		22d. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
	22e PHYSICIAN'S NAME (TYPE OR PRINT) Charles P. Adamo M.D.		22f. ADDRESS Chestertown, Md. 21620									
	23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/27/84		23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery		23d. LOCATION CITY OR TOWN Chestertown, Md.		COUNTY	STATE		
BP	24 FUNERAL DIRECTOR <i>Willis Wells</i>		ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR JAN 26 1984		25b. REGISTRAR'S SIGNATURE <i>John J. Conwell</i>				

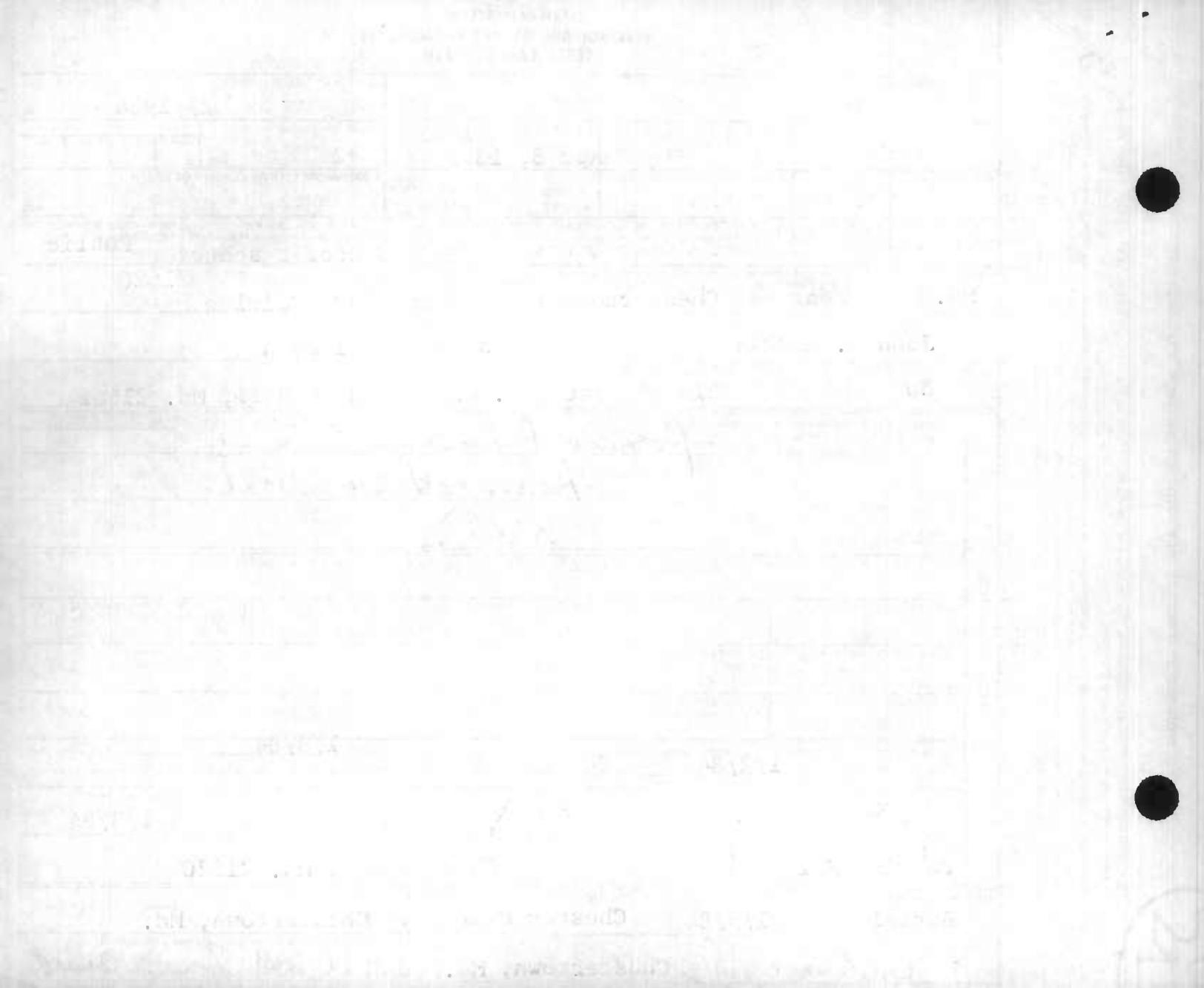


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 4 0 2 1 2 0								
										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
Frances Beeks Morris						January 3, 1984					1984	7:00a.m.						
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS						
Female			White		Apr 8, 1891		92			MONTHS	DAYS	HOURS	MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.								
U.S.A. MD			U.S.A.				Kent											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Chestertown			Kent & Queen Anne's Hospital										School teacher			Public		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		21620						
Md.			Kent		Chestertown					RFD Fairlee								
14. FATHER'S NAME FIRST			MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST							
John E. Morris						Jessie Walraven												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
no			219 36 6940		Wm. Morris			Rock Hall, Md. 21661										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Possible Pulmonary Embolus</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Possible Heart M.I.</u> (c) <u>68CVD</u>																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1/2/84 to 1/3/84, 1984, to 1/3/84, 1984, that (I) (we) last saw the deceased alive on 1/2/84, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <u>Patrick Molony</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/3/84									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS Chestertown, Md. 21620															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 1/5/84		23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery		23d. LOCATION CITY OR TOWN Chestertown, Md.			COUNTY	STATE							
24. FUNERAL DIRECTOR NAME			ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR JAN 10 1984			25b. REGISTRAR'S SIGNATURE <u>John J. Conroy</u>									



Item 4 per ph. 1/26/84 4/17/84 jlb

## DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. WRITE THE WORD "PENDING" IN PENCIL IN ITEM 19a. RETAIN PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONE. PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR
JAMES TILDEN POWELL						<input checked="" type="checkbox"/>	XX	1/3/84	19	10	45P	M
3. SEX	RACE	4. DATE OF BIRTH MONTH DAY YEAR	5. AGE (IN YEARS) MONTH DAY YEAR	6. IF UNDER 1 YR. MONTHS DAYS	7. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
Male	White 65	3/10/1913	62 yrs 7 mos			<input checked="" type="checkbox"/>	XX	1/3/84	11	73	84 P	M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH					
DELAWARE		USA			<input checked="" type="checkbox"/>	<input type="checkbox"/>	Kent county					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
CHESTERTOWN		KENT + Queen Anne's Hosp. Plumb & Elect.								SELF		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
MD		KENT		MILLINGTON		<input checked="" type="checkbox"/>		212 CRANE ST 21651				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST					
Samuel			Powell Sr.	Florence T.			Smith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
yes WWII		212-12-0738		Florence W. Powell		Same wife						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Cardiac Arrest due to Arteriosclerotic CVD</b>												
IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>Hypertension, Diabetes Mellitus, History of previous heart attack</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>Robert W. Farr</i>		TITLE (SPECIFY) Deputy		M.D.		MEDICAL EXAMINER		DATE SIGNED 1/5/84				
EXAMINER'S NAME (TYPE OR PRINT)		Robert W. Farr, M.D.		Chestertown, Kent Cty, Md., 21620 ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 1-7-84		23c. NAME OF CEMETERY OR CREMATORIAL MILLINGTON Cem.		23d. LOCATION CITY OR TOWN MILLINGTON		COUNTY KENT		STATE MD		
24. FUNERAL DIRECTOR NAME Fellows F.H. Box 270		ADDRESS MILLINGTON, MD		25a. DATE REC'D. BY REGISTRAR JAN 18 1984		25b. REGISTRAR'S SIGNATURE <i>Jeanne J. Cawley</i>						
BP												
DHMH - 17 (VR A15 ME (5)) 15M 7/77												

June 2001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 4 0 2 1 2 2					
										REG. NO.					
1. FOR STATE REGISTRAR			DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
			William James Ransom								1	18	84		11:15 A.M.
SEX: <b>MALE</b>			4. RACE: <b>NEGRO</b>		5. DATE OF BIRTH <b>JUNE 6<sup>TH</sup>, 1905</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN.			
7a. BIRTHPLACE <b>WEST VIRGINIA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Kent</b>		MD.					
10. CITY OR TOWN OF DEATH <b>Chestertown</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kent and Queen Anne's Hospital</b>			12a. USUAL OCCUPATION (IF NOT IN such FACILITY, OR INDUSTRY OR TRADE) <b>BRICK MASON</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>						
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>KENT</b>		13c. TOWN <b>GOLTS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>RT. 1 BOX 2 HURLOCK-GOLTS RD</b>		<i>21637</i>				
14. FATHER'S NAME FIRST <b>PALMER</b>			MIDDLE <b>RANSOM</b>		15. MOTHER'S MAIDEN NAME FIRST <b>ADA</b>			MIDDLE		UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>284-10-6794</b>			17. INFORMANT <b>CATHERINE RANSOM</b>			ADDRESS <b>wife same</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>Adeno carcinoma of the Stomach</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>					
<b>IMMEDIATE CAUSE (a)</b> <i>1519</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>DUE TO, OR AS A CONSEQUENCE OF</b> (b) _____ <b>DUE TO, OR AS A CONSEQUENCE OF</b> (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Urinary Tract Infection</b>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) <del>this hospital</del> attended the deceased from <b>July 16</b> , 19 <b>83</b> , to <b>JAN 18</b> , 19 <b>84</b> , that (I) <del>never</del> lost saw the deceased alive on <b>JAN 17</b> , 19 <b>84</b> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>never</del> (did not) view the body after death.										22c. DATE SIGNED <b>JAN 24, 1984</b>					
22b. SIGNATURE <i>Charles P. Adams</i>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <b>JAN 24, 1984</b>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles P. Adams</b>			22f. ADDRESS <b>Chestertown, Maryland</b>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1/23/84</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>WESLEY HENRY CEM.</b>			23d. LOCATION IN OR OUT <b>GOLTS</b>		KENT		COUNTY <b>MARYLAND</b>		
24. FUNERAL DIRECTOR <b>EDW. FELLOWS &amp; SON MILLINGTON MD 21651</b>			25a. DATE RECEIVED BY REGISTRAR <b>JAN 30 1984</b>			25b. REGISTRAR'S SIGNATURE <i>John G. Coniff</i>									

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

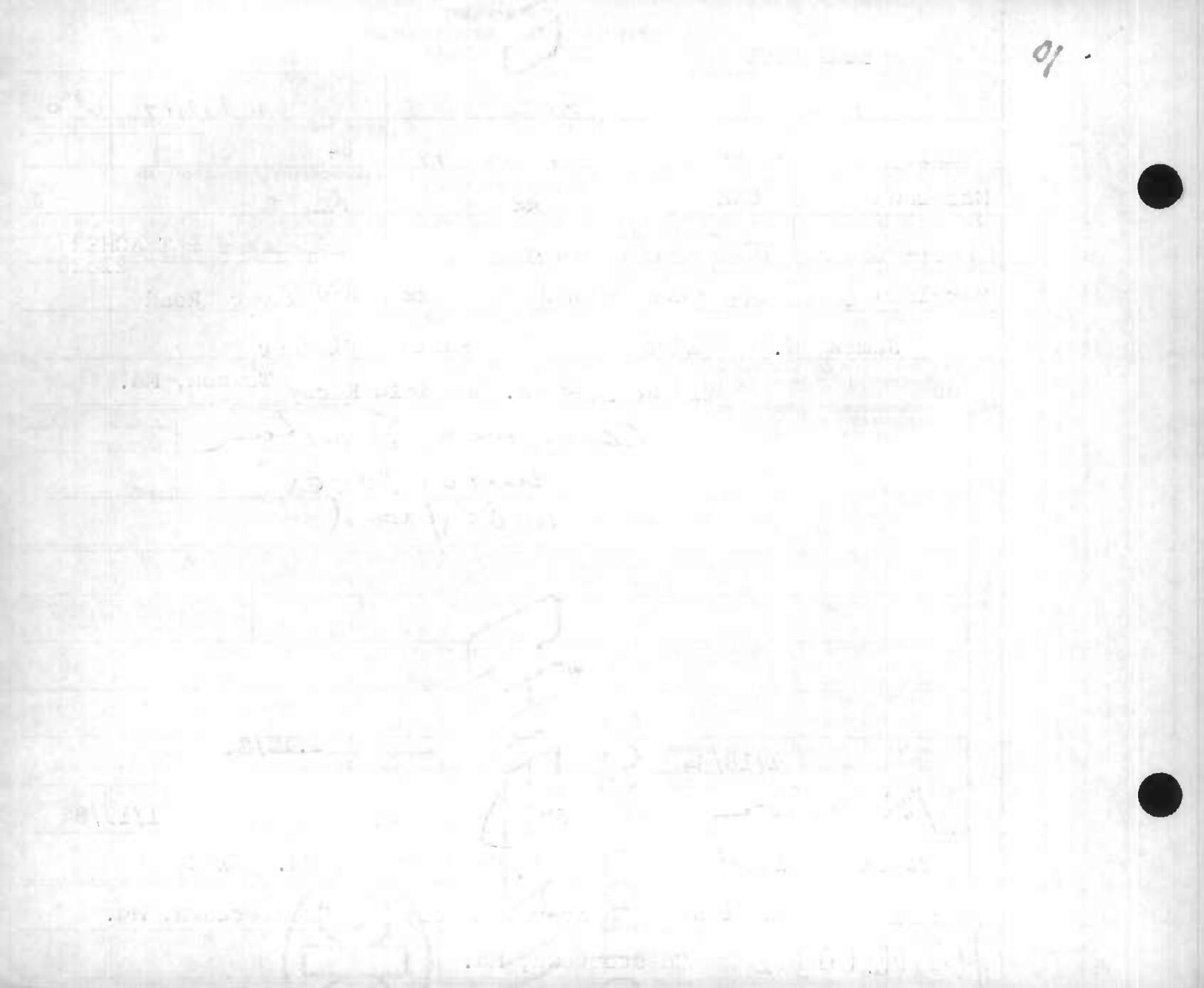
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of her death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 0 2 1 2 3	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Edna ROSS			Edna		Ross	1/18/84					84	6 <sup>30</sup> P M	
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
female			white		2 20 99		84						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent MD.						
10 CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MAGNOLIA HALL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker & TEACHER			12b. KIND OF BUSINESS OR INDUSTRY 21620					
13a. STATE Maryland			13b. COUNTY Queen Anne		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RFD River Road				
14. FATHER'S NAME FIRST James W.			MIDDLE	LAST Kirby	15. MOTHER'S MAIDEN NAME Annie Fischer								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 40 1499		17. INFORMANT A. Rayfield Kirby			ADDRESS Towson, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of rectum</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1541 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DOUE TO, OR AS A CONSEQUENCE OF (b) <i>metastases</i>													
DOUE TO, OR AS A CONSEQUENCE OF (c) <i>widely spread</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) this hospital attended the deceased from _____, 19_____, to 1/18/84, 19_____, that (I) (we) last saw the deceased alive on 1/18/84 19_____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Patrick Molony</i> DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED 1/19/84													
23. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick Molony ADDRESS Chestertown, Md. 21620													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/21/84		23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery			23d. LOCATION CITY OR TOWN Chestertown, Md.		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME <i>J. Collins Wells</i>			ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR 'JAN 27 1984			25b. REGISTRAR'S SIGNATURE <i>J. G. Cawell</i>					

01



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death.

IMPORTANT: If Item 21 is marked on Item 18 (shows any injury, or other traumatic event, had and/or did not have an effect on the cause of death), attach a separate sheet of paper and describe the injury.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHB 4 0 2 1 2 4  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>Bernard</b>	MIDDLE <b>James</b>	LAST <b>Ryan</b>	2a. DATE OF DEATH <b>January 29, 1984</b>	MONTH YEAR	2b. HOUR <b>11:05a M</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>1</b> DAY <b>18</b> YEAR <b>1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Kent</b>				
10. CITY OR TOWN OF DEATH <b>Chestertown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kent &amp; Queen Anne's Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TRUCK DRIVER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Food Store</b>				
13a. STATE <b>MD.</b>		13b. COUNTY <b>CAROLINE</b>	13c. CITY OR TOWN <b>HENDERSON</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Box 175-83</b> 21640 <b>CAROLINE ACRES MOBILE PARK</b>				
14. FATHER'S NAME FIRST <b>WILLIAM J. RYAN</b>		MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST <b>DELIA BOYD</b>		MIDDLE	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>WW II 216-14-8102</b>		17. INFORMANT ADDRESS <b>Mrs. Winona Ryan - Caroline Acres Mobile Park Box 175-83 21640</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1539</b> IMMEDIATE CAUSE (a) <b>Carcinoma Colon c Re section</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Infective Ch</b>										
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal &amp; Liver Failure</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									22c. DATE SIGNED <b>1/30/84</b>	
22b. SIGNATURE <b>W. Henderson</b>		22c. DEGREE <b>MD</b>		22d. ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. Henderson</b>		22f. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-3-84</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Lake View Cem.</b>		23d. LOCATION CITY OR TOWN <b>BALTO. Md.</b>		COUNTY		
24. FUNERAL DIRECTOR NAME <b>J. DeGillie - 7527 Harford Rd.</b>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Cahill</b>				

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\* Charcoal Heavies  
DEUTZ B600

INTERVIEW BY RYAN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3  
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3  
should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	4	0	2	1	2	5
										REG. NO.						
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
		Wilson				Benjamin	Weaver	January 30, 1984						6:10 P.M.		
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White			August 10, 1915			68			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.					
Maryland		USA						Kent			MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Chestertown		The Kent & Queen Anne's Hospital, Inc.			Farmer and Carpenter (ret.)			Farming and Hv. Construction								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
Maryland		QueenAnne's		Henderson					R.D. #2, Box 104, 21640							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST						
		Robert	Benjamin	Weaver				Lucy	Mae	Wilson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS								
No		217-36-1203			Wife			R.D. #2, Box 104								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18b. IMMEDIATE CAUSE (a)			18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY:  1539		Curse of Cid														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Due to, or as a consequence of  Underwear manufactures														
		(c) Due to, or as a consequence of  -ASCD														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost sow the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE					DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
22d. THE PHYSICIAN'S NAME (TYPE OR PRINT)		Patrick A. Molony, M.D.			22e. ADDRESS			Chestertown, Md. 21620								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE				
Burial		Feb. 2, 1984		Chesterfield Cemetery			Centreville, Q.A.Co., Md.									
24. FUNERAL DIRECTOR NAME		Barton Funeral Home			ADDRESS			25. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
		James H. Barton, Jr., Centreville, Md. 21617						FEB 7 1984			John J. Cawley					

*Hand book of MTCB*